

ADDRESS BY

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BEFORE

THIRD INTERNATIONAL CONFERENCE ON  
CONTINUING MEDICAL EDUCATION

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THANK YOU FOR THAT KIND INTRODUCTION AND YOUR WARM WELCOME. IT IS A GENUINE PLEASURE TO JOIN YOU TODAY, AND TO DISCUSS A TOPIC SO IMPORTANT TO OUR PROFESSION AND TO THE TIMES IN WHICH WE LIVE.

IT IS IMPOSSIBLE FOR ME TO ADDRESS THIS QUESTION, "WHY CME?" AS EFFECTIVELY AS I MIGHT WITHOUT BRIEFLY GLANCING BACK OVER MY SHOULDER AT MY RECENTLY-COMPLETED SERVICE AS THE U.S. SURGEON GENERAL, TO SEE WHAT IT TAUGHT ME.

WHEN PRESIDENT REAGAN ASKED ME TO SERVE AS SURGEON GENERAL, IT WAS, TO SAY THE LEAST, AN INVITATION TO AN ADVENTURE, A LEAP INTO THE GREAT UNKNOWN. I HAD NO IDEA WHAT THE JOB DESCRIPTION WAS, -- AND YOU DON'T DARE ASK.

ER ALL, QUITE FULFILLED PROFESSIONALLY, AS SURGEON-  
F THE CHILDREN'S HOSPITAL OF PHILADELPHIA AND  
PROFESSOR OF PEDIATRIC SURGERY AT THE UNIVERSITY OF  
PENNSYLVANIA. AND I WASN'T, AT FIRST, ENTIRELY CERTAIN OF THE  
FULL JOB DESCRIPTION THE PRESIDENT WAS ASKING ME TO ASSUME --  
BESIDES, OF COURSE, PLACING WARNING LABELS ON CIGARETTE PACKAGES.

IN FACT, A LITTLE VOICE IN THE BACK OF MY MIND TOLD ME I COULD BE  
WALKING INTO THE FOOTSTEPS OF THE NOTED PHYSICIST, DR. ROBERT  
MILLIKAN, WHOSE YOUNG DAUGHTER ONCE ANSWERED THE TELEPHONE BY  
SAYING, "YES, THIS IS WHERE DR. MILLIKAN LIVES, BUT HE'S NOT THE  
KIND OF DOCTOR WHO DOES ANYBODY ANY GOOD."

OR, AS MY THIRD SON DAVID ONCE SAID TO A FRIEND, "YES, I WANT TO BE A DOCTOR, BUT I WANT TO BE A REGULAR DOCTOR, NOT A DOCTOR LIKE MY FATHER."

I ASKED MYSELF, AM I GOING TO BECOME KNOWN TO CHILDREN EVERYWHERE AS THE KIND OF GENERAL WHO DOESN'T FIGHT ANY WARS?


I FOUND OUT SOON ENOUGH, THOUGH, THAT THERE ARE INDEED WARS TO FIGHT IN THIS NATION OF OURS. THERE ARE BATTLES TO BE WAGED AGAINST THE CAUSES OF PREMATURE DEATH AND DISABILITY, AGAINST THE ILLNESSES THAT MAKE THE AGING PROCESS AN AGONIZING, RATHER THAN ENRICHING, EXPERIENCE.

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WE ARE AT WAR WITH THE SICKNESS THAT DEVASTATE THE  
POOR AND DISADVANTAGED, AND THE PHYSICAL AND  
PSYCHOLOGICAL INJURIES THAT DESTROY FAMILIES AND STEAL  
THE JOY FROM CHILDHOOD.

AS SURGEON GENERAL, I HAVE HAD THE GOOD FORTUNE OF  
MEETING AND VISITING WITH THOUSANDS OF PEOPLE  
THROUGHOUT THE COUNTRY, AND I GAINED A VALUABLE  
LESSON FROM THOSE ENCOUNTERS. I HAVE SEEN FIRSTHAND  
THAT THE AMERICAN PEOPLE AND THEIR PHYSICIANS ARE  
READY AND WILLING TO FIGHT IN THESE WARS AND, IN FACT,  
ARE ALREADY DOING SO.

I BELIEVE HISTORY WILL REMEMBER THE 1980'S AS THE DECADE IN WHICH PEOPLE, BY AND LARGE, BEGAN TO RECOGNIZE THE OPPORTUNITY THEY HAD TO TAKE CHARGE OF THEIR HEALTH AND DID, IN A SENSE, CHANGE THEIR OPTIONS AND AFFECT THEIR OWN DESTINIES.

CE OF THIS IS ALL AROUND US, FROM EXERCISE VIDEO CASSETTES TO THE EVER-PRESENT OAT BRAN ON OUR GROCERY STORE SHELVES. IT IS ALSO MATERIALIZING IN MORE CONCRETE WAYS. SMOKING CONTINUES TO DECLINE. CASUAL DRUG USE HAS, ACCORDING TO STUDIES, LEVELED OFF AND IS, IN SOME CASES, DROPPING. ALCOHOL CONSUMPTION IS ALSO DOWN, BUT ESPECIALLY HARD LIQUOR; PEOPLE ARE TURNING FROM THAT TO BEER, WINE OR EVEN WATER.

LIFESTYLES ARE BEING RESTRUCTURED BECAUSE OF A GREATER AWARENESS OF THE CAUSES OF HEART DISEASE, CANCER AND STROKE. THE ELDERLY WHO PLAN AHEAD -- SAY, AT 45 OR SO, -- CAN LIVE QUALITY YEARS AFTER 65 BECAUSE THEY HAVE CHANGED LIFESTYLES AND TAKEN CHARGE OF THEIR HEALTH.

HEALTH CARE IS NO LONGER AN ABSTRACT CONCEPT TO MILLIONS OF AMERICANS -- IT IS A VERY PERSONAL COMPONENT IN THE MAKEUP OF OUR EVERYDAY LIVES. AND I THINK THE AMERICAN PEOPLE ARE BEGINNING TO UNDERSTAND PUBLIC HEALTH, -- THANKS TO AIDS.

THIS CHANGE FOR THE BETTER IN THE NATIONAL MINDSET BRINGS WITH IT SIGNIFICANT RESPONSIBILITIES FOR THOSE OF US IN THE MEDICAL PROFESSION.

~~FIRST~~, WE HAVE TO BE MORE THAN A PASSIVE RESOURCE IN THIS MOVEMENT TOWARD A HEALTHIER AMERICA. IT IS NOT SUFFICIENT FOR US TO SIT BACK AS INTERESTED SPECTATORS, PROVIDING AN ANSWER OR TWO WHEN ASKED. WE HAVE AN OBLIGATION TO BE ACTIVE PARTNERS IN THESE MATTERS OF DISEASE PREVENTION, OF HEALTH MAINTENANCE AND HEALTH PROMOTION, PLAYING A HAND-IN-HAND ROLE WITH THOSE SEEKING TO WARD OFF DISEASE AND DISABILITY.

OUR RESPONSIBILITY EXTENDS TO, AND IN FACT, IS MADE MORE ACUTE BY THOSE WHO DO NOT NECESSARILY FIT INTO THIS CATEGORY OF SELF-HELPING AMERICANS. WE HAVE A SACRED OBLIGATION TOWARD THE POOR, THE AGED, THE PHYSICALLY HANDICAPPED, THOSE WHO LIVE IN DISADVANTAGED RURAL AND INNER-CITY COMMUNITIES, AND, OF COURSE, MOTHERS AND CHILDREN, THE ESSENTIAL CORE OF PUBLIC HEALTH.



ADDRESSING THEIR NEEDS REQUIRES A PRACTICE OF MEDICINE THAT IS PROACTIVE. A PRACTICE OF MEDICINE THAT IS AGGRESSIVE. A PRACTICE OF MEDICINE THAT IS IN STEP WITH THE CURVE OF HISTORY, NOT TRAILING IT. IT NECESSITATES THAT EACH OF US BE AS PROFICIENT AND WELL-VERSED AS HUMANLY POSSIBLE IN THE PRINCIPLES AND TECHNIQUES OF HEALTH CARE IN THE 1990'S.

IT REQUIRES, IN SHORT, A DEVOTION TO CONTINUING MEDICAL EDUCATION.

CME SHOULD, IN ANY EVENT, BE AN INHERENT PART OF OUR BELIEF SYSTEM AS PHYSICIANS. THE ERA IN WHICH WE LIVE MAKES IT CRITICAL THAT WE EMBRACE THE CONCEPT OF CONTINUOUS LEARNING. EMBRACE IS THE KEY WORD. YOU HAVE TO HAVE THE MINDSET TO DO CME. ONCE YOU SLIP OUT OF THAT MINDSET, IT IS VERY, VERY HARD TO GET BACK IN.

AS HISTORY IS MADE, SO ARE THE PRACTICES AND STANDARDS OF HEALTH CARE. HEALTH AND MEDICINE ARE CONSTANTLY AFFECTED BY THE ENVIRONMENT AND BY SOCIETAL NEEDS.

IT WAS A CENTURY AGO THAT CITIES AND STATES BECAME MORE CONCERNED ABOUT WHERE TO BURY THEIR DEAD AND ABOUT THE POTENTIALLY ADVERSE IMPACT OF UNSAFE DRINKING WATER AND CONTAMINATED MILK SUPPLIES. THEY ESTABLISHED PUBLIC HEALTH AND HYGIENE DEPARTMENTS TO OVERSEE THE PROPER HANDLING OF THOSE COMMODITIES.

IN THE 1930'S, THE HUNGER THAT PERMEATED THE COUNTRY DURING THE DEPRESSION LED TO THE EMERGENCE OF VITAMINS AND OF NUTRITION AS A SCIENCE.

DURING WORLD WAR II, MEDICAL SCIENCE DEVELOPED ANTIBIOTICS WHICH DID A LOT TO SAVE THE LIVES OF OUR WOUNDED.

AND, THROUGHOUT THE LATTER PART OF THE CENTURY, STAGGERING LEAPS IN BIOTECHNOLOGY HAVE SPAWNED A SERIES OF GOLDEN AGES...A GOLDEN AGE OF SURGERY...A GOLDEN AGE OF DRUG THERAPY...A GOLDEN AGE OF ORGAN TRANSPLANTATION, AND SO ON.

THIS HASN'T ALL BEEN HYPE AND HYPERBOLE BY ANY MEANS. HEALTH CARE TECHNOLOGY HAS TAKEN REMARKABLE STRIDES IN THE LAST THREE DECADES AND, BECAUSE IT HAS, COUNTLESS LIVES HAVE BEEN SAVED AND EXTENDED.

I BELIEVE, THOUGH, THAT WE ARE IN THE EARLY STAGES OF A NEW PERIOD IN MEDICAL HISTORY. A PERIOD IN WHICH WE LOOK AT TECHNOLOGY WITH A MORE CRITICAL EYE AND A SHARPER PERSPECTIVE. A PERIOD IN WHICH WE REAFFIRM THE ROLE OF THE HUMAN TOUCH IN PROVIDING HEALTH CARE.

TECHNOLOGY IS, AS I NOTED, A BLESSING, BUT IT IS A MIXED ONE. THE PUBLIC HAS, ALL TOO FREQUENTLY, COME TO BELIEVE IN THE MAGIC OF MEDICINE, TO EQUATE THE TECHNOLOGICAL WITH THE MIRACULOUS. AND, TOO OFTEN, SOME OF OUR COLLEAGUES HAVE PROMOTED THAT KIND OF REVERENCE FOR TECHNOLOGY, THE BELIEF THAT MACHINES ARE SELF-PERPETUATING AGENTS OF SALVATION RATHER THAN SIMPLY LIMITED TOOLS.

THAT'S YESTERDAY AND TODAY. I DON'T BELIEVE IT WILL BE THE CASE TOMORROW. IN FACT, I BELIEVE IT IS CHANGING RIGHT NOW.

THERE IS AN INCREASING SENTIMENT IN THE PUBLIC THAT TECHNOLOGY DOES NOT, -- CANNOT -- ANSWER ALL OF ITS NEEDS OR, FOR THAT MATTER, WHAT IT NEEDS AND WANTS THE MOST.

I'VE SEEN THIS GROWING ANTIPATHY TOWARD HIGH TECH IN NEONATAL INTENSIVE CARE. I'VE WATCHED IT CLOSELY, -- AFTER ALL, I DID BUILD THE FIRST NEONATAL INTENSIVE CARE UNIT IN THE COUNTRY, -- BACK IN WHAT MY CHILDREN WOULD REFER TO AS OLDEN TIMES. THIS IS A FIELD THAT HAS SEEN EXTENSIVE TECHNOLOGICAL GROWTH, FROM INFANT RESPIRATORS AND SMALL-BORE ENDOTRACHEAL TUBES TO MICRO BLOOD GAS ANALYZERS.

THIS MINIATURIZATION OF SPECIALIZED EQUIPMENT HAS BROUGHT NEW HOPE TO SICK INFANTS. AT THE SAME TIME, HOWEVER, IT HAS NOT ALWAYS BROUGHT COMFORT AND ASSURANCE TO THEIR PARENTS, ESPECIALLY IN THE EXORBITANT COSTS. WITH THE INCLUSION OF MORE COMPLEX EQUIPMENT, MORE PERSONNEL WITH PARTICULAR AREAS OF EXPERTISE ARE INVOLVED. WHERE PARENTS USED TO INTERACT WITH ONE PHYSICIAN WHO KNEW EVERYTHING ABOUT THEIR NEWBORN SON OR DAUGHTER, TODAY THEY DON'T ALWAYS KNOW WHERE TO TURN WITH THEIR QUESTIONS AND CONCERNS.

SEVERAL DOCTORS AND NURSES, IN THESE CASES, KNOW WILL THEIR OWN PARTICULAR PERSPECTIVE OF THE BABY'S CASE. DOES ANYONE HAVE A GRASP OF THE WHOLE? HOW MANY FEEL THE NEED TO SEEK THAT MORE COMPREHENSIVE VIEW?

TECHNOLOGY, IN CIRCUMSTANCES LIKE THESE, HAS BROUGHT US THE EPITOME OF IMPERSONALIZED CARE; COMPUTERS, WIRES, TUBES AND MONITORS, -- WATCHING THE BABY, CHECKING EVERY VITAL FUNCTION AND A FEW THAT AREN'T, -- ALL IN PLACE OF HUMAN EYES AND HANDS.

NEONATES AREN'T ALONE. WE DEAL WITH THEIR GREAT-GRANDPARENTS IN THE SAME WAY IN THEIR FINAL ILLNESSES.

HAVE WE REACHED THE ULTIMATE IN CARE, OR IS THERE A BETTER WAY? I HAVE TO BELIEVE IN THE LATTER.

I THINK THE PUBLIC BELIEVES THE BALANCE BETWEEN TECHNOLOGY AND HUMANITY IN MEDICAL CARE HAS TIPPED TOO FAR TO ONE SIDE. THIS IS EVIDENT IN THE GROWING NUMBER OF PEOPLE WHO OPPOSE THE USE OF EXTRAORDINARY MEASURES TO PROLONG THE AGONY OF DYING. THEY SEE, IN THOSE CIRCUMSTANCES, TECHNOLOGY AS A CURSE RATHER THAN A BLESSING.

WE ARE BEGINNING TO HEAR THE PUBLIC SAY THAT IT NEEDS AND WANTS THE KIND OF SYSTEMS THAT PROMOTE HEALTHFUL LIVING OR THAT HELP OLDER PEOPLE AND PEOPLE WITH DISABILITIES OR CHRONIC ILLNESSES LIVE AS HEALTHFULLY AS POSSIBLE AND INDEPENDENTLY IN THEIR OWN HOMES.



AND, WITH THAT KIND OF POSITIVE, LIFE-AFFIRMING HARDWARE, THEY WANT RESPONSIBLE, KNOWLEDGABLE, UP-TO-DATE PHYSICIANS -- NOT COMPUTERS, BUT PEOPLE -- TO PROVIDE PERSONAL, COMPETENT, COMPASSIONATE CARE.

IT IS THEN OUR DUTY AS PROFESSIONALS TO PROVIDE THAT KNOWLEDGABLE, UP-TO-DATE CARE. IT SHOULD ALSO BE OUR DESIRE, OUR PRIVILEGE AND OUR ULTIMATE FULFILLMENT.

ANOTHER KEY FACTOR IN THIS NEW PERIOD IN MEDICAL HISTORY IS THE GROWTH OF THE SELF-HELP MOVEMENT. WHEN, TWO YEARS AGO, I CONVENED A SURGEON GENERAL'S WORKSHOP ON SELF-HELP, I DISCOVERED AN ESTIMATED 15 MILLION PEOPLE DEEPLY, DEVOTEDLY, INVOLVED IN THIS INITIATIVE. I NOW BELIEVE I SEVERELY UNDERESTIMATED THAT NUMBER.

THESE PEOPLE, CUTTING ACROSS ALL SOCIAL, RACIAL, ETHNIC AND ECONOMIC LINES, ARE PROVIDING LEADERSHIP IN AREAS IN WHICH THEY PERCEIVE TRADITIONAL MEDICINE IS NOT: HEALTH PROMOTION, DISEASE PREVENTION, COUNSELING AND MUTUAL AID, -- WHAT SOME CALL COGNITIVE MEDICINE.

THE SELF-HELP MOVEMENT EMBRACES A WIDE ARRAY OF ACTIVITIES, EVERYTHING FROM ALCOHOLICS ANONYMOUS AND ITS SISTER ORGANIZATIONS, SMOKING CESSATION GROUPS AND PROGRAMS, DRUG COUNSELING AND TREATMENT, TO AN ASSORTMENT OF SUPPORT GROUPS FOR PERSONS WITH FAMILY, PERSONALITY, SEXUALITY AND INFECTIOUS DISEASE PROBLEMS, AS WELL AS THOSE RECOVERING FROM A MAJOR HEALTH ORDEAL.

THESE GROUPS AND INDIVIDUALS ARE REMARKABLY SUCCESSFUL AT WHAT THEY DO. THEY ARE HELPING PEOPLE, IN LARGE NUMBERS.

HAVING SAID THAT, THOUGH, I HAVE A CONCERN, A MAJOR CONCERN. IT DISTURBS ME THAT SOME PEOPLE WHO NEED THE HELP OF PROFESSIONALS WITH MEDICAL TRAINING MAY NOT BE GETTING IT. ARE THEY PUTTING THEIR HEALTH AND THEIR LIVES IN PERIL AS A CONSEQUENCE?

I BELIEVE THERE IS ALWAYS A ROLE FOR TRADITIONAL MEDICINE TO PLAY. SELF HELP IS SUPPORTIVE, AN ADJUNCT. PHYSICIANS AND NURSES SHOULD LOOK TOWARD TAKING A PARTNERSHIP ROLE WITH THE SELF-HELP MOVEMENT, PROVIDING THAT NEEDED EXPERTISE FOR THOSE IN NEED OF HELP AND SUPPORT WITHOUT TAKING AWAY ANY OF THEIR PREROGATIVES.

THIS, AGAIN, REQUIRES AN AGGRESSIVE, FORWARD-THINKING APPROACH. THESE PEOPLE AND ORGANIZATIONS WORK WITH SOME OF THE MOST SERIOUS PUBLIC HEALTH PROBLEMS WE FACE TODAY -- SUBSTANCE ABUSE, INCLUDING CIGARETTES, -AIDS, HEART DISEASE, CANCER. YOU CAN'T PLAY IN THIS LEAGUE WITHOUT KNOWING TODAY'S RULES.

IF TRADITIONAL MEDICAL PROVIDERS ARE TO BECOME INVOLVED IN THIS SELF-HELP AREA, AND MY INCLINATION IS THAT THEY SHOULD, THEN CONTINUING MEDICAL EDUCATION IS NOT A LUXURY, IT IS A NECESSITY IN DEALING WITH CONTEMPORARY HEALTH PROBLEMS.

CME, OF COURSE, IS NOT A NEW IDEA. IT PREDATES HIPPOCRATES. BUT, IT IS IN THIS CENTURY, THAT CONTINUING MEDICAL EDUCATION HAS MADE THE TRANSITION FROM A VAGUE NOTION OF WHAT PHYSICIANS SHOULD DO IN THEIR SPARE TIME TO A MORE-PROGRAMMATIC, BETTER-DEFINED ENTERPRISE.

SIR WILLIAM OSLER, A NOTED CLINICIAN AND ONE OF THE KEY THINKERS ON THIS SUBJECT IN THE EARLY PART OF THE CENTURY, GAVE A SPEECH AT JOHNS HOPKINS UNIVERSITY IN 1905 IN WHICH HE SAID THREE THINGS THAT ARE STILL QUOTED TODAY.

HE TOLD HIS AUDIENCE, FIRST, THAT PHYSICIANS MUST BE LIFELONG STUDENTS TO RETAIN COMPETENCE.

THEN, HE SAID, THAT CONTINUAL STUDY IS AN ANTIDOTE AGAINST PREMATURE SENILITY AMONG PHYSICIANS, THAT IT PROVIDES REFRESHMENT AND RENOVATION. THAT'S WHY I DID NOT RETIRE ON THE TWO OCCASIONS I HAD THE OPPORTUNITY TO DO SO.

AND, FINALLY, HE SAID THAT HE HAD A FIXED IDEA THAT, AND I QUOTE "ABOUT THE USELESSNESS OF MEN ABOVE 60 YEARS OF AGE, AND THE INCALCULABLE BENEFIT IT WOULD BE IN COMMERCIAL AND PROFESSIONAL LIFE IF, AS A MATTER OF COURSE, MEN STOPPED WORK AT THIS AGE."

I APPLAUD OSLER'S FIRST TWO POINTS, AND MY 73 YEARS ON THIS EARTH HAVE GIVEN ME THE CHARITY TO FORGIVE HIM THE FOOLISHNESS OF HIS THIRD.

OSLER SAID, ON ANOTHER OCCASION, SOMETHING I FOUND QUITE INTERESTING. HE DIVIDED PHYSICIANS INTO TWO DISTINCT GROUPS -- THE ROUTINIST, WHO FALLS INTO A RUT, IN OSLER'S WORDS, "VICTIMIZED BY THE VICE OF INTELLECTUAL IDLENESS," AND THE RATIONALIST, THE DOCTOR WHO SEES THE CARE OF THE PATIENT AS A PROBLEM TO BE SOLVED, AND WHO WILL GO TO ANY LENGTHS TO FIND THE ANSWER TO THAT PROBLEM.

APPLYING THE OSLER DEFINITIONS TO TODAY'S WORLD, A WORLD WITH UNPRECEDENTED HEALTH CARE CHALLENGES AND CHANGING PERCEPTIONS ABOUT MEDICINE, WE FIND WE SIMPLY DON'T HAVE THE LUXURY OF AFFORDING ROUTINISTS IN THE RANKS, WHILE OUR RATIONALISTS ARE VALUABLE COMMODITIES INDEED.

THE AVAILABILITY OF CONTINUING MEDICAL EDUCATION TODAY IS FAR GREATER THAN IT WAS EARLY IN THE CENTURY, AND AFFORDS MORE DOCTORS TODAY THE OPPORTUNITY TO BE WELL-INFORMED AND BETTER ABLE TO PROVIDE SUPERLATIVE CARE.

WHEN FORMAL CME BEGAN IN THE EARLY 1900'S, IT WAS LITTLE MORE THAN REMEDIAL EDUCATION TO MAKE UP FOR GAPS IN MEDICAL SCHOOL TRAINING. TO A LARGE DEGREE, IT STAYED THAT WAY UNTIL THE 1930'S.



THAT'S WHEN A SCHISM STARTED TO APPEAR, CLEAVING THE PHYSICIANS OF THAT TIME INTO TWO GROUPS. THE EXTRAORDINARY SCIENTIFIC ADVANCES OF THAT EARLY PART OF THE CENTURY CREATED A GAP BETWEEN THOSE PHYSICIANS WHO STAYED UP-TO-DATE ON NEW DEVELOPMENTS AND THOSE LESS INSPIRED PRACTITIONERS WHOSE LEARNING ENDED WITH THEIR DEGREE.

THE PROFESSION BECAME VERY CONCERNED ABOUT THE WIDE EXTREMES IN HEALTH CARE QUALITY BEING PROVIDED TO PATIENTS AND SENTIMENT GREW THAT, IF MEMBERS WERE NOT MONITORED MORE CLOSELY INTERNALLY, THEN GOVERNMENT AGENCIES MIGHT STEP IN TO DO SO. WHERE HAVE I HEARD THAT BEFORE?

GIVEN THE NUMBER OF STATES THAT CURRENTLY HAVE MANDATORY CME LAWS ON THE BOOKS, I WOULD SAY THEIR CONCERNS HAD A TINGE OF PROPHECY IN THEM.

SOON, CME TOOK ON A MORE DEFINITE FORM AS ACADEMIA, COMMUNITY HOSPITALS AND CLINICS AND, LATER, PRIVATE ENTREPRENEURS BEGAN PROVIDING EDUCATIONAL SERVICES. A FURTHER CATALYST TO PROGRESS WAS THE EXPLOSION OF BIOLOGICAL SCIENCE RESEARCH AND DEVELOPMENT DURING WORLD WAR II AND, SUBSEQUENTLY, THE ACCELERATION IN GOVERNMENT-SPONSORED RESEARCH AT THE NATIONAL INSTITUTES OF HEALTH.

SO THAT'S WHERE CONTINUING MEDICAL EDUCATION STANDS TODAY, A DECENTRALIZED, DIVERSE ARRAY OF PROGRAMS OFFERED BY A VARIETY OF SPONSORS.

NOW, THE QUESTION ASKED IN THE TITLE OF MY ADDRESS, "WHY CME?" SEEMS ABSURD ON ITS FACE. AFTER ALL, THIS IS A CONCEPT CENTURIES OLD. IT IS INHERENT WITHIN THE SCIENCE OF MEDICINE. THERE SEEMS TO BE LITTLE REASON FOR ME TO HAVE COME 3,000 MILES TO ANSWER THE QUESTION, "WHY CME?"

AND YET, WE ALL KNOW THAT ALL IS NOT NIRVANA, THAT THERE ARE PHYSICIANS WHO DO QUESTION THE QUALITY AND ORGANIZATION OF CONTINUING EDUCATION AS IT STANDS TODAY. THERE ARE THOSE WHO RESENT ATTENDING LECTURES THAT THEY FEEL TELL THEM WHAT THEY ALREADY KNOW. THERE ARE THOSE WHO FEEL THEY ARE SPENDING TOO MUCH MONEY, WASTING TOO MUCH TIME FOR PROGRAMS THAT HAVE LIMITED VALUE.

THERE ARE THOSE WHO QUESTION CME'S BASIC VALUE, SAYING THAT THERE IS NO EMPIRICAL PROOF THAT CME IS TRULY EFFECTIVE IN CHANGING PHYSICIAN PRACTICES IN ANY MEANINGFUL OR LASTING WAY. THEY ASK THE RHETORICAL QUESTION, "CAN YOU MAKE GOOD DOCTORS OUT OF BAD ONES BY MAKING THEM ATTEND CME EXERCISES?"

I WANT TO MAKE A FEW POINTS OF MY OWN REGARDING CONTINUING MEDICAL EDUCATION, SOME OBSERVATIONS, SUGGESTIONS AND CRITICISMS. BUT, FIRST, LET ME DISMISS THE IRRELEVANCIES.

DOES CME MAKE BAD DOCTORS INTO GOOD ONES? PROBABLY NOT. BUT THAT'S NOT THE PROVINCE OF ADULT EDUCATION. THE QUESTION OF BAD DOCTORS FALLS WITHIN THE PARAMETERS OF PEER REVIEW, NOT CME.

FURTHERMORE, I DON'T BELIEVE THAT THE VALIDITY OF CONTINUING MEDICAL EDUCATION IS DEPENDENT UPON WHETHER OR NOT WE CAN SUPPORT IT WITH EMPIRICAL DATA. IT WAS PLATO THAT SAID, "EDUCATION IS A LIFELONG PROCESS." NOW, THAT IS TRUE FOR ALL PEOPLE, BUT NONE MORE SO THAN FOR THOSE OF US IN THE MEDICAL PROFESSION. OURS IS A CONTINUAL LEARNING EXPERIENCE. THAT IS UNDERSTOOD IN THE OATH WE TAKE. OUR PATIENTS DEMAND IT. OUR PROFESSION DEMANDS IT.

AND YOU DON'T NEED A DOUBLE BLIND STUDY TO VALIDATE THE NEED FOR CONTINUING EDUCATION.

NOW, HAVING SAID THAT, I ALSO BELIEVE WE MUST SHAPE CME TO MEET THE GROWING NEEDS OF PHYSICIANS IN THE 1990'S.

WHILE I BELIEVE THERE IS SOMETHING TO GAIN FROM CLASSROOM LECTURES AND JOURNAL READINGS IN CONVEYING IMPORTANT, BROAD-BASED INFORMATION, EFFECTIVE CME IN TODAY'S WORLD MUST GO A STEP BEYOND.

IF CME'S GOAL IS TO HELP PRACTITIONERS PROVIDE BETTER CARE TO THEIR PATIENTS, THEN TRULY EFFECTIVE CME MUST BE MORE TARGETED TO SPECIFIC PATIENT NEEDS.

THIS IS A CASE IN WHICH MODERN TECHNOLOGY CAN BE UTILIZED TO BRING ABOUT GREATER PERSONAL CARE. THROUGH THE USE OF PERSONAL COMPUTERS AND MODEMS, PHYSICIANS CAN LINK THEIR OFFICES TO UNIVERSITIES, TO HOSPITALS, CLINICS, AND DATA BASES. IN FACT, I HAVE BEEN CAMPAIGNING, AND WILL CONTINUE TO LOBBY FOR, STRONGER DATA COLLECTION AT THE NATIONAL LIBRARY OF MEDICINE TO MAKE IT POSSIBLE FOR DOCTORS TO DRAW UPON THOSE RESOURCES FROM THE CONVENIENCE OF THEIR OFFICES.

DATA LINKS CAN EVEN BE USED TO SHARE INFORMATION FROM COLLEAGUE TO COLLEAGUE RATHER THAN WAITING FOR A CHANCE MEETING IN A CORRIDOR OR CAFETERIA.

I ALSO BELIEVE THE PROVIDERS OF CONTINUING EDUCATION HAVE TO DO A THOROUGH SELF-EXAMINATION TO DETERMINE WHETHER THEY ARE DOING JUSTICE TO THEIR PROGRAMS. ARE THEY GIVING THEM SUFFICIENT PRIORITY?

I HAVE SEEN TOO MANY CME MANAGERS AT ORGANIZATIONS AND INSTITUTIONS WHO DON'T MAKE THEIR PROGRAMS AS STRONG AS THEY COULD POSSIBLY BE, BECAUSE THEY AREN'T GIVEN THE STAFFING OR THE FINANCIAL RESOURCES TO DO SO.

AND IT IS NO SECRET THAT THE CME PROGRAMS AT MEDICAL SCHOOLS ARE THE WEAK SISTERS ON CAMPUS. MANY SCHOOL ADMINISTRATORS DON'T LIKE THE PROGRAMS, DON'T REALLY UNDERSTAND THEM AND, IN GENERAL, GIVE THEM SHORT SHRIFT.



AS A RESULT, WHAT WE HAVE TOO OFTEN IS CONTINUING EDUCATION THAT RESEMBLES JUNIOR HIGH -- LECTURES AND SLIDE SHOWS. THAT IS NOT WITHOUT VALUE, BUT WE CAN DO SO MUCH BETTER. THE TECHNOLOGY IS THERE. THE RESOURCES CAN BE THERE. ALL THAT IS LACKING IS THE INCLINATION TO DO SO.

PROVIDERS AND CONSUMERS OF CME NEED TO REALIZE THAT WE ARE IN AN AWFUL MESS IN REFERENCE TO HEALTH CARE IN THIS COUNTRY. WE HAVE ALL SORTS OF PEOPLE IN BUSINESS, IN CONGRESS, IN THE PROFESSION CALLING FOR A NATIONAL HEALTH SERVICE. WE HAVE DOCTORS DISLIKING THEIR PATIENTS AND WE HAVE A PUBLIC LESS THAN SATISFIED WITH THEIR PHYSICIANS.

I DO NOT BELIEVE IT HAD TO DEVELOP THAT WAY AND MIGHT NOT HAVE IF THOSE RESPONSIBLE FOR CME HAD FACED THE CHANGING TIMES, ISSUE BY ISSUE, AND HAD DEVELOPED LESS EXPECTATION ON THE PART OF THE PUBLIC AND TRAINED DOCTORS TO BE MORE RESPONSIVE TO THE NEEDS OF PATIENTS.

IN CME, THE SHOE IS ON THE OTHER FOOT. PHYSICIANS ARE THE CONSUMERS IN THIS ARRANGEMENT. THEY NEED TO BE DEMANDING CONSUMERS, MAKING THEIR NEEDS KNOWN AND INSISTING UPON CME BEFITTING MEDICAL CARE IN THE 1990'S. CME IS NOT JUST NEW PHARMACEUTICALS AND NEW PROCEDURES. IT IS KEEPING UP WITH ATTITUDES IN AND ABOUT MEDICINE.

THOSE WHO ARE LEARNING HAVE THE OBLIGATION TO DEMAND WHAT THEY WANT AND NEED. AND THE EDUCATORS HAVE A RESPONSIBILITY TO GIVE THE KIND OF EDUCATION PHYSICIANS NEED, BUT DON'T NECESSARILY WANT.

MEDICAL PROFESSIONALS MUST BE DEMANDING BECAUSE THEY HAVE DEMANDING CONSTITUENCIES. THE PUBLIC IS INSISTING, RIGHTFULLY SO, ON DOCTORS WHO ARE NOT ONLY CARING AND CONCERNED, BUT WHO HAVE ALSO ALREADY ABSORBED YESTERDAY'S NEW MEDICAL DEVELOPMENTS.

WE HAVE SEVERAL IMPERATIVES BEFORE US.

WE HAVE AN ELDERLY CARE IMPERATIVE. A GREATER PROPORTION OF MEDICAL TREATMENT IN THE YEARS AHEAD WILL BE DEVOTED TO THE NATION'S FASTEST GROWING POPULATION GROUP, THOSE 65 AND OLDER. WE ARE IN THE MIDST OF A SENIOR CITIZEN BOOM, AND IT WILL AFFECT THE WAY WE APPROACH HEALTH CARE IN THE UNITED STATES.

ALL TOO OFTEN, ELDERLY CARE IS PERCEIVED AS LITTLE MORE THAN PATIENT MAINTENANCE, MANAGING THE PATIENT'S INEVITABLE DECLINE IN HIS OR HER TWILIGHT YEARS.

BUT, ELDERLY CARE SHOULD BE SO MUCH MORE THAN THAT, AND CAN BE WHEN THE PRACTITIONER IS MOTIVATED AND WELL-VERSED IN CONTEMPORARY GERIATRIC PRACTICES.

THE AGING PROCESS CAN BE A LIVING PROCESS, NOT A DYING ONE. HUMAN AGING CAN BE SICKNESS-FREE, DISEASE-FREE, JUST LIKE ANY OTHER PERIOD IN ONE'S LIFE. AMONG OTHER THINGS, IT TAKES A CARING PHYSICIAN WITH BOTH THE INCLINATION AND THE KNOWLEDGE.

WE ALSO HAVE A CHILDRENS' IMPERATIVE. SO MANY CHILDREN IN THIS COUNTRY HAVE A DIRE NEED FOR QUALITY HEALTH CARE. ON ONE FRONT, WE HAVE THE 12 MILLION CHILDREN WHO GROW UP IN POVERTY, THE LARGEST SINGLE GROUP OF POOR PEOPLE IN THE UNITED STATES.

THESE ARE CHILDREN FROM FAMILIES WITHOUT ACCESS TO HEALTH CARE. THEY ARE UNLIKE THE AGED POOR WHO, AT LEAST, HAVE MEDICARE AND SOMETIMES MEDICAID. POOR CHILDREN, VERY FREQUENTLY, HAVE NO ACCESS WHATSOEVER TO MEDICAL TREATMENT.

AND THEN THERE ARE THE ABUSED CHILDREN, THE VICTIMS OF FAMILY VIOLENCE. THIS IS AN ISSUE THAT COMES TO LIGHT PERIODICALLY WHEN AN EXTREME CASE, LIKE THE STEINBERG EPISODE, IS DISCOVERED. BUT, ALL TOO OFTEN, CHILD ABUSE GOES UNDISCOVERED AND THOUSANDS OF LITTLE BOYS AND GIRLS SUFFER IN SILENCE.

WHEN WE TALK ABOUT CONTINUING MEDICAL EDUCATION, WE WOULD BE REMISS IF WE DIDN'T CONCENTRATE UPON THE TRAINING NECESSARY TO RECOGNIZE THE HEALTH CARE NEEDS OF CHILDREN IN POVERTY, AS WELL AS TO RECOGNIZE THE SYMPTOMS OF CHILD ABUSE. WE MUST UTILIZE CME TO SAVE YOUNG LIVES.

MEDICINE TODAY IS MORE THAN JUST STRAIGHT TEXTBOOK MEDICINE. PEOPLE ARE ASKING DOCTORS TO HANDLE SOCIOECONOMIC PROBLEMS. AND, ALTHOUGH THEY CAN'T BE ALL THINGS TO ALL PEOPLE, THEY DO HAVE TO KNOW SOMETHING ABOUT THE BRIDGES AND THE GAPS BETWEEN THE WORLD OF SOCIOECONOMICS AND THE HEALTH PROBLEMS ASSOCIATED WITH THEM.

WE HAVE A DISEASE IMPERATIVE, AS WELL, SPECIFICALLY THE DISEASE CALLED AIDS. AFTER EIGHT YEARS OF A DISEASE WITH NO CURE AND NO VACCINE, THE PROFESSION IS BECOMING COMPLACENT AND THE PUBLIC, -- NOT IDENTIFYING WITH MOST PEOPLE WITH AIDS, -- HAS ASSUMED A WE-THEY POSTURE. NO MEDICAL PROFESSIONAL IN THE UNITED STATES CAN AFFORD TO TURN HIS OR HER BACK ON THIS DISEASE THAT WILL GO ON KILLING WELL INTO THE NEXT CENTURY.

WE HAVE A TREMENDOUS RESPONSIBILITY IN DEALING WITH AIDS. WE NEED TO MAINTAIN STRONG SUPPORT FOR PROGRAMS THAT PROVIDE INFORMATION TO PEOPLE AT RISK OF GETTING AIDS, AND WE NEED TO ASSURE MEDICAL SERVICES TO THOSE WHO NEVER DID GET THE MESSAGE -- AND ARE DYING.

AND, AS DIFFICULT AS IT IS, WE MUST CONVINCE PEOPLE WITH AIDS TO CHANGE THE BEHAVIOR THAT GAVE THEM THE DISEASE. THEY HAVE NO INCENTIVE TO DO SO. THERE'S NO CARROT AT THE END OF THE STICK. BUT WE HAVE TO TRY ANYWAY, FOR THE SAKE OF SOCIETY, TO STOP THE SPREAD OF THE VIRUS.

THAT'S WHY IT IS INCUMBENT ON EVERY INDIVIDUAL IN THE HEALTH CARE ARENA TO LEARN AS MUCH AS POSSIBLE ABOUT AIDS, TO SPREAD THE WORD AS EFFECTIVELY AS POSSIBLE, TO BE EFFECTIVE COMBATANTS AGAINST THIS INSIDIOUS DISEASE.



AND, FINALLY, WE HAVE A PREVENTIVE HEALTH IMPERATIVE. EACH OF US, ARMED WITH THE MOST UP-TO-DATE KNOWLEDGE AVAILABLE, SHOULD BE CARRYING THE FLAG AGAINST ONE OF THE LEADING KILLERS OF OUR TIME, CIGARETTES.

YES, WE HAVE WON SOME VICTORIES IN THIS AREA. PER CAPITA CIGARETTE SALES HAVE DECLINED EACH YEAR SINCE 1973. SMOKING IS NO LONGER SOCIALLY ACCEPTABLE, AND IT IS BANNED IN MORE PUBLIC PLACES THAN EVER BEFORE.

BUT THE BATTLE IS FAR, FAR FROM OVER. THERE ARE STILL 50 MILLION AMERICANS WHO CONTINUE TO SMOKE, REDUCING THEIR LIFESPANS WITH EACH INHALATION. MORE THAN 380,000 MEN AND WOMEN DIE EACH YEAR FROM SMOKING-ATTRIBUTABLE DISEASE. THOSE NUMBERS ARE CONSTANT REMINDERS OF WHY WE MUST NEVER BECOME COMPLACENT.

A CORE FUNCTION OF CONTINUING MEDICAL EDUCATION SHOULD BE THE CONSTANT DISSEMINATION OF THE MOST RECENT INFORMATION THE HARMS OF SMOKING BUT ESPECIALLY HOW TO USE THAT KNOWLEDGE TO COUNSEL THEIR PATIENTS, OBTAIN AND DISPLAY EDUCATIONAL MATERIALS FOR THEIR OFFICES, HELP PROMOTE SMOKING CESSATION PROGRAMS IN THEIR COMMUNITIES, AND USE THEIR INFLUENCE WITH ELECTED OFFICIALS TO PROMOTE STIFFER TOBACCO-CONTROL POLICIES. THE CIGARETTE INDUSTRY HAS VAST AMOUNTS OF MONEY AND A HISTORY OF ABUSING POWER ON ITS SIDE. WE HAVE COLLECTIVE INFLUENCE AND MORAL STRENGTH ON OURS. I BELIEVE THAT THOSE QUALITIES, COMBINED WITH ACCURATE INFORMATION AND A DEEPLY-HELD COMMITMENT TO LIFE, WILL MAKE US THE EVENTUAL VICTORS IN THIS WAR.

THE SAME COULD BE SAID IN ESSENTIALLY EVERY REGARD ABOUT ALCOHOL, -- WITH THE CAVEAT THAT ALCOHOL DOES NOT DAMAGE ALL WHO USE IT, WHERE TOBACCO DOES

NONE OF US WOULD HAVE ENTERED THE MEDICAL PROFESSION WERE IT NOT FOR OUR BELIEF IN THE VALUE OF LIFE AND OUR CALLING TO TRY TO PRESERVE AND ENHANCE LIFE. CONTINUING MEDICAL EDUCATION IS A VITAL, INDISPENSABLE TOOL IN PRACTICING OUR BELIEFS AND IN PURSUING OUR BELIEFS AND IN PURSUING OUR CALLING.

HIPPOCRATES ONCE SAID, "HEALING IS A MATTER OF TIME, BUT IT IS SOMETIMES ALSO A MATTER OF OPPORTUNITY." OPPORTUNITY, IN THIS CASE, IS NOT A QUESTION OF CHANCE. WE PRESENT GREATER OPPORTUNITIES FOR OURSELVES BY ACQUIRING GREATER KNOWLEDGE. IT IS THE ESSENCE OF OUR PROFESSION. THANK YOU VERY MUCH.

THANK YOU FOR THAT KIND INTRODUCTION AND YOUR WARM WELCOME. IT IS A GENUINE PLEASURE TO JOIN YOU TODAY, AND TO DISCUSS A TOPIC SO IMPORTANT TO OUR PROFESSION AND TO THE TIMES IN WHICH WE LIVE.

IT IS IMPOSSIBLE FOR ME TO ADDRESS THIS QUESTION, "WHY CME?" AS EFFECTIVELY AS I <sup>MIGHT</sup> ~~CAN~~ WITHOUT BRIEFLY GLANCING BACK OVER MY SHOULDER AT MY RECENTLY-COMPLETED SERVICE AS THE U.S. SURGEON GENERAL. *To see what it taught me*

WHEN PRESIDENT REAGAN ASKED ME TO SERVE AS SURGEON GENERAL, IT WAS, TO SAY THE LEAST, AN INVITATION TO AN ADVENTURE, A LEAP INTO THE GREAT UNKNOWN. I HAD NO IDEA WHAT THE JOB DESCRIPTION WAS, -- AND YOU DON'T DARE ASK.

WE ARE AT WAR WITH THE SICKNESSES THAT DEVASTATE THE POOR AND DISADVANTAGED, AND THE PHYSICAL AND PSYCHOLOGICAL INJURIES THAT DESTROY FAMILIES AND STEAL THE JOY FROM CHILDHOOD.

AS SURGEON GENERAL, I HAVE HAD THE GOOD FORTUNE OF MEETING AND VISITING WITH THOUSANDS OF PEOPLE THROUGHOUT THE COUNTRY, AND I GAINED A VALUABLE LESSON FROM THOSE ENCOUNTERS. I HAVE SEEN ~~AND THEIR PHYSICIANS~~ FIRSTHAND THAT THE AMERICAN PEOPLE ARE READY AND WILLING TO FIGHT IN THESE WARS AND, IN FACT, ARE ALREADY DOING SO.

THIS MINIATURIZATION OF SPECIALIZED EQUIPMENT HAS BROUGHT NEW HOPE TO SICK INFANTS. AT THE SAME TIME, HOWEVER, IT HAS NOT ALWAYS BROUGHT COMFORT AND ASSURANCE TO THEIR PARENTS, ESPECIALLY IN THE EXORBITANT COSTS. →

WITH THE INCLUSION OF MORE COMPLEX EQUIPMENT, MORE PERSONNEL WITH PARTICULAR AREAS OF EXPERTISE ARE INVOLVED. WHERE PARENTS USED TO INTERACT WITH ONE PHYSICIAN WHO KNEW EVERYTHING ABOUT THEIR NEWBORN SON OR DAUGHTER, TODAY THEY DON'T ALWAYS KNOW WHERE TO TURN WITH THEIR QUESTIONS AND CONCERNS.

SEVERAL DOCTORS AND NURSES, IN THESE CASES, KNOW WELL THEIR OWN PARTICULAR PERSPECTIVE OF THE BABY'S CASE. DOES ANYONE HAVE A GRASP OF THE WHOLE? <sup>How many</sup> ~~DO ANY~~ FEEL THE NEED TO SEEK THAT MORE COMPREHENSIVE VIEW?

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